Doctors should do as they're told – myth or reality?

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The end of the 20th century has seen the endorsement of patient-centeredness as a core component of any clinical consultation. Doctors working within or contracted to the NHS are increasingly seen less as autonomous professionals and more as civil servants, answering to a number of masters. In the post-millennial NHS where do the boundaries of personal and professional autonomy lie?

Does doctor know best?

Doctors may have greater knowledge of the diseases and treatments than those whom they treat. This unequal balance of power has been reversed by greater patient participation in decision-making and the importance given to respecting patients' autonomy. However, there are situations where a doctor may be ethically obliged to say 'no' to a patient or patient's representative. Conflicts arise when doctors decide that something a patient desires is not in their best interests. Would doctors be expected to proceed with a patient's request even if absolutely sure it will lead to harm? Even a car mechanic, however, might refuse to customize a car in a manner that jeopardizes its roadworthiness. A doctor may refuse to put the patient through unnecessary hazard, such as refusing an anorexic who asks for gastric stapling or subject patients to X-rays which will not change the prognosis or management.

An intervention may be in a patient's best interests but still a doctor may have to deny it. In the NHS, doctors may have a role in saying 'no' to avoid wasting limited resources. Resources are usually rationed according to clinical need. Homelessness is not per se an indication for admission to hospital. If a struggling actor asks for aesthetic surgery to improve his looks in order to obtain work, this is not within the gift of state-sponsored medicine. GPs are urged to prescribe the cheapest cost-effective drugs, sometimes irrespective of a patient's wishes. One view is that these decisions have been made at a policy level. In reality considerable leeway is often granted to the treating doctor.

Conscience problems

The Human Rights Act states that everyone has the right to freedom of thought, conscience and religion; this right includes freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance. Freedom to manifest one's religion or belief shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals or for the protection of the rights and freedoms of others.

Doctors' values may manifest as a right to conscientiously object to offering certain medical services. In state medicine, 'conscience' can introduce inequity and inefficiency. Patients must shop among doctors to receive the service to which they are entitled, wasting resources. Some patients, less informed, may fail to receive a service that they were entitled to. Savulescu concedes that doctors should have a right of conscience in ethically complex cases, but also argues that services the state has agreed to provide do not fall into this category. Problems arise where a doctor in good faith does not believe that a patient meets criteria for a service. That doctor will have his morals and beliefs scrutinized, especially if other doctors are prepared to interpret guidelines more permissively.

Professional conscience may be an important part of evidence-based ethics. The total exclusion

of professional and/or personal conscience is to remove a brake on the influence of politics and fashion on medical ethics. The 20th century saw the perpetration of vast atrocities in the name of progress by fundamentalist secular states, with the complicity of doctors. In the these regimes some doctors acquiesced out of fear for their jobs and lives but others embraced ideas society has since labelled as abhorrent.

Court medical

Some may argue that a military-style model of ethical conscience should apply to medical decisions. In the armed forces, one is obliged to disobey an order which conflicts with the Geneva Convention. Not to have the backing of the Convention when disobeying orders, however, risks court-martial. Savulescu calls for sanctions against doctors who fail to satisfy patients' rights.[1] If a proposed action is permitted by an approved code of conduct, then there should be a responsibility on a doctor to facilitate it. Soldiers take on a commitment to risk their lives if necessary and to obey orders. This appears reasonable. There is little time for debate in battle. Similarly, perhaps emergency situations call for led-algorithms: at a cardiac arrest in hospital, the team leader decides if it is ever necessary to deviate from protocol. References to comparative front-lines are rhetorical at best. Doctors are perceived as professional civilians. If human rights legislation applies to other public sector workers, it should apply to doctors also.

If self-interest and self-preservation are not deemed sufficient grounds for conscientious objection, how can other values be? This approach confuses conscience with cowardice. The example that is used is a female anesthetist who will not maintain a patient's airway in a CT scanner because of the radiation risk. The problem with this view is that a presumption of heroism and self-sacrifice nullifies both concepts – it becomes a license for exploitation and unsafe practice. Would we be less critical of the doctor if she were pregnant? Consider another example: current guidance is that doctors should not get involved in a bomb site. Current training is that one should have appropriate protective clothing, be part of a coordinated response, which involves the police and fire service controlling the area and making sure that there are no further hazards. When a bomb went off on a bus outside BMA House in 2005, doctors rushed in to help. They continued helping despite warnings from the police that there might be a second bomb.[2] Their selfless desire to help was contrary to best practice. Would we criticize someone following protocol and not rushing in, or for not doing as they were told?

In conclusion

There are two key issues; professional autonomy and professional/personal conscience. If ethical decisions should not be made at the bedside, doctors should follow algorithms based on statute and case law, permit what the state allows and act as champions for patient wishes where there is a case for further allowance. Doctors conversely should never obstruct anything which the state permits, providing the patient is adequately informed, irrespective of their own moral views. Such a view does not allow for different interpretations of statute, case law and codes of conduct. The approach does not allow for laws which are unjust. A doctor without ethics need not be more than superficially patient-centred if he is state-controlled. If doctors should not be weighing issues at the bedside, the 'reductio ad absurdum' is that it is a waste of time teaching ethics to doctors. It is better to teach a state-sponsored code of conduct, perhaps based on regularly updated societal consensus, or perhaps based on what the government decides. Such a notion seems a little frightening.

A sliding scale of reasonableness could apply to personal conscience in a secular state composed of a diversity of moral outlook. To exclude personal conscience entirely can be arguably discriminatory against one's workforce. Most would agree that someone who has no intention of physical contact with a woman should not elect to become a gynaecologist, but some might argue that a conscientious objection to abortion does not necessarily preclude a career in gynaecology. One might certainly expect less of a problem with conscientious objection to abortion in general practice, especially if there is an obligation to refer to a colleague, and the option of self-referral to a specialist service.

Not only has the language of rights led to increasing demands by individuals, but the 21st-century doctor has to reconcile quality with cost effectiveness, and in effect serve two masters: the customer is always right, but so is the area manager.

Moreover conscience has become a casualty of cost effectiveness. Some say this ought to be so. Others ask why healthcare workers should be denied legal rights which other workers enjoy. If doctors have equal rights as humans and taxpayers to those who they serve, then perhaps this is irrespective and independent of any special status.

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